

Health Status/ Eligibility Form

Case #: _____

Date Form Completed: ___ ___/___ ___/___ ___

Completed by: _____

1. **Has your home had weatherization work done in the past 10 years? (If yes, then not eligible for HHI program, if no or unsure, proceed).** _____yes _____no _____unsure
Are you currently in the HEAP Program? _____yes _____no

2. Do you have children living with you who are **16 years old or less with asthma; or an infant(s) under 12 months of age?**
_____ yes _____ no

--OR--

3. Do you have any **adults 65 or over living in the home with a chronic upper respiratory condition(s) (COPD, emphysema, asthma)?**
_____ yes _____no *If "yes" proceed to #4; if "no" to questions 2 and 3, do not qualify.*

4. Eligibility is based on total gross annual income of **all** persons living in the home. Based on this guideline, do you qualify?
_____ yes _____ no

<u>Household Size</u>	<u>Income</u>	<u>Household Size</u>	<u>Income</u>
1	\$21,660	6	\$59,060
2	\$29,140	7	\$66,540
3	\$36,620	8	\$74,020
4	\$44,100	9	\$81,500
5	\$51,580	10	\$88,980

For households with more than 10 members, add \$7,480 for 200% per member

*If "no," they are not qualified.
If "yes," please collect the following, and inform them that someone will be contacting them about a home visit and the application process.*

- 5. a) Are any of the children infants under 12 months old? _____yes _____no
- b) Was asthma diagnosed by a doctor? _____yes _____no
- c) Do any of the children have other chronic respiratory issues such as reactive airway disease, cystic fibrosis, or chronic allergies with daily medication? _____yes _____no
- d) Was the adult's chronic respiratory condition diagnosed by a doctor? _____yes _____no

6. In the last 12 months has your child or the adult 65 or over had an emergency department visit/ urgent care visits or hospitalization for asthma or chronic upper respiratory disease?

___ yes ___ no ___ **child** ___ **adult**

If "yes," How many? _____

and

Where? ___ Rainbow(child) or University Hospitals(adult)

___ Cleveland Clinic

___ Metro Medical Center

___ Fairview

___ Other: _____

7. Is your child or the adult 65 or over currently being treated by an asthma/ lung specialist, allergist, or other doctor?

___ yes ___ no

Physician Name: _____

Type of Dr: _____

___ **child** ___ **adult**

Clinic: _____

Name _____

Address _____

City _____ Zip _____

Daytime Phone _____

Secondary Phone _____

Referred By: _____

(Agency, clinic, relative, friend, etc)

Any additional Information: